AMENDED IN ASSEMBLY JUNE 2, 2003

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CALIFORNIA LEGISLATURE—2003–04 REGULAR SESSION

ASSEMBLY BILL No. 1628

Introduced by Assembly Member Frommer

February 21, 2003

An act to amend ~~Section~~ *Sections 1262.5 and* 1371.4 of the Health and Safety Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

AB 1628, as amended, Frommer. Health care.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, regulates and licenses health care service plans by the Department of Managed Health Care and makes the willful violation of the act a crime. The act authorizes a health care service plan to require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.

This bill would require a nonparticipating hospital to contact an enrollee's health care service plan to obtain the enrollee's medical record information prior to admitting the enrollee as an inpatient for poststabilization treatment following emergency treatment, or prior to transferring an enrollee to a nonparticipating hospital for

poststabilization treatment following emergency treatment under specified conditions. The bill would require a nonparticipating hospital that admits an enrollee who is not clinically stabilized to contact the enrollee's health care service plan as soon as reasonably possible after the enrollees medical condition is clinically stabilized. The bill would prohibit a nonparticipating hospital that is required to contact the patient's health care service plan, and fails to do so, from billing the patient for poststabilization services.

The bill would specify that contact made to comply with the bill's provisions between a health care service plan or a health care service plan's subcontractor, and a nonparticipating hospital or nonparticipating physician, shall not be interpreted to mean there is an implied contract between the 2 parties for purposes of reimbursement.

Because a violation of the bill would be a crime, it would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. (a) It is the intent of the Legislature in enacting this act to protect patients with health benefits coverage from being billed in the event of a dispute between a hospital and a health care service plan, where the hospital has not contacted the health care service plan to access a patient's medical record and the health care service plan makes the record available.

(b) It is not the Legislature's intent to change the existing law concerning the duties of a hospital or physician and surgeon to a patient who presents in an emergency department of a licensed hospital.

(c) It is not the Legislature's intent to change existing law concerning the responsibilities that a health care service plan and an emergency health care provider *including a hospital* have in

relation to each other, including the duty to reimburse for services provided.

SEC. 2. *Section 1262.5 of the Health and Safety Code is amended to read:*

1262.5. (a) Each hospital shall have a written discharge planning policy and process.

(b) The policy required by subdivision (a) shall require that appropriate arrangements for posthospital care, including, but not limited to, care at home, in a skilled nursing or intermediate care facility, or from a hospice, are made prior to discharge for those patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning. If the hospital determines that the patient and family members or interested persons need to be counseled to prepare them for posthospital care, the hospital shall provide for that counseling.

(c) The process required by subdivision (a) shall require that the patient be informed, orally or in writing, of the continuing health care requirements following discharge from the hospital. The right to information regarding continuing health care requirements following discharge shall apply to the person who has legal responsibility to make decisions regarding medical care on behalf of the patient, if the patient is unable to make those decisions for himself or herself. In addition, a patient may request that friends or family members be given this information, even if the patient is able to make his or her own decisions regarding medical care.

(d) (1) A transfer summary shall accompany the patient upon transfer to a skilled nursing or intermediate care facility or to the distinct part-skilled nursing or intermediate care service unit of the hospital. The transfer summary shall include essential information relative to the patient's diagnosis, hospital course, pain treatment and management, medications, treatments, dietary requirement, rehabilitation potential, known allergies, and treatment plan, and shall be signed by the physician.

(2) A copy of the transfer summary shall be given to the patient and the patient's legal representative, if any, prior to transfer to a skilled nursing or intermediate care facility.

(e) A hospital shall establish and implement a written policy to ensure that each patient receives, at the time of discharge,

information regarding each medication dispensed, pursuant to Section 4074 of the Business and Professions Code.

(f) A contract between a general acute care hospital and a health care service plan that is issued, amended, renewed, or delivered on or after January 1, 2002, may not contain a provision that prohibits or restricts any health care facility's compliance with the requirements of this section.

(g) If a representative of a hospital fails to call a health care service plan to obtain the medical record of an enrollee of that health care service plan who is being treated in the hospital's emergency department prior to admitting the enrollee for poststabilization care as an inpatient or prior to transferring the enrollee for poststabilization care to another hospital, pursuant to subdivision (j) of Section 1371.4, the hospital shall not bill the patient for any medical services provided following stabilization.

SEC. 3. Section 1371.4 of the Health and Safety Code is amended to read:

1371.4. (a) A health care service plan, or its contracting medical providers, shall provide 24-hour access for enrollees and providers to obtain timely authorization for medically necessary care, for circumstances where the enrollee has received emergency services and care is stabilized, but the treating provider believes that the enrollee may not be discharged safely. A physician and surgeon shall be available for consultation and for resolving disputed requests for authorizations. A health care service plan that does not require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition or active labor need not satisfy the requirements of this subdivision.

(b) A health care service plan shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.

(c) Payment for emergency services and care may be denied only if the health care service plan reasonably determines that the

emergency services and care were never performed; provided that a health care service plan may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.

(d) If there is a disagreement between the health care service plan and the provider regarding the need for necessary medical care, following stabilization of the enrollee, the plan shall assume responsibility for the care of the patient either by having medical personnel contracting with the plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the plan agree to accept the transfer of the patient as provided in Section 1317.2, Section 1317.2a, or other pertinent statute. However, this requirement shall not apply to necessary medical care provided in hospitals outside the service area of the health care service plan. If the health care service plan fails to satisfy the requirements of this subdivision, further necessary care shall be deemed to have been authorized by the plan. Payment for this care may not be denied.

(e) A health care service plan may delegate the responsibilities enumerated in this section to the plan's contracting medical providers.

(f) Subdivisions (b), (c), (d), (g), and (h) shall not apply with respect to a nonprofit health care service plan that has 3,500,000 enrollees and maintains a prior authorization system that includes the availability by telephone within 30 minutes of a practicing emergency department physician.

(g) The Department of Managed Health Care shall adopt by July 1, 1995, on an emergency basis, regulations governing instances when an enrollee requires medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to requests for treatment authorization.

(h) The Department of Managed Health Care shall adopt, by July 1, 1999, on an emergency basis, regulations governing instances when an enrollee in the opinion of the treating provider

requires necessary medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to a request for treatment authorization from a treating provider who has a contract with a plan.

(i) The definitions set forth in Section 1317.1 shall control the construction of this section.

(j) (1) A hospital shall contact an enrollee's health care service plan to obtain the enrollee's medical record information prior to admitting the enrollee for poststabilization care as an inpatient or prior to transferring the enrollee for poststabilization care to another hospital, if all of the following apply:

(A) The hospital is able to obtain the name of the enrollee's health care service plan.

(B) The hospital is a nonparticipating California hospital with a nonparticipating physician that wants to admit the enrollee as an inpatient in a nonparticipating hospital for poststabilization care following emergency services, or wants to transfer the enrollee to a nonparticipating hospital for poststabilization care following emergency services.

(C) The health care service plan has a practicing emergency physician who is available within 30 minutes, who has access to the enrollee's medical records, and who can transmit the records to the provider via telephone, facsimile, or e-mail.

(D) The health care service plan can provide authorization for poststabilization care and obtain information concerning cost sharing that the nonparticipating hospital may charge the enrollee under the enrollee's coverage.

(2) A hospital required to contact an enrollee's health care service plan regarding authorization for poststabilization care pursuant to this subdivision shall do so as soon as reasonably possible, but not until the enrollee's medical condition is clinically stabilized, as determined by the attending physician.

(3) If a hospital required to contact an enrollee's health care service plan regarding authorization for poststabilization care pursuant to this subdivision fails to do so, the hospital shall not bill the enrollee for medical services provided following ~~stabilization. Nothing in this subdivision shall prohibit a nonparticipating hospital from billing a health care service plan for care provided prior to the enrollee being stabilized as documented in the~~

~~enrollee's clinical record, including care provided pursuant to admission to the nonparticipating hospital prior to the enrollee's being clinically stabilized. Nothing in this subdivision shall require a nonparticipating hospital to request prior authorization for admission of an enrollee who is not clinically stabilized prior to admission into the nonparticipating hospital.~~

~~(4) If a nonparticipating hospital admits an enrollee who is not clinically stabilized into the hospital, the nonparticipating hospital shall contact the enrollee's health care service plan as soon as reasonably possible after the enrollee's medical condition is clinically stabilized, as determined by the attending physician. If a nonparticipating hospital does not contact the enrollee's health care service plan regarding authorization of poststabilization care once the enrollee is clinically stabilized, the hospital shall not bill the enrollee for any medical services provided following stabilization.~~

~~(5)~~ *stabilization.*

(4) Paragraphs (1), (2), *and* (3)~~, and (4)~~ do not apply to physicians providing medical services at the hospital.

~~(6)~~

(5) For purposes of this subdivision, a *representative of the* hospital is *not* required to make ~~not~~ more than one telephone call to the number provided in advance by the health care service plan. *The representative of the hospital that makes the telephone call may be, but is not required to be, a physician.*

~~(7)~~

(6) Contact between a health care service plan or a subcontractor of a health care service plan, and a nonparticipating hospital or nonparticipating physician, that is made to comply with the provisions of this article shall not be interpreted to mean there is an implied contract between the two parties for purposes of reimbursement.

(7) An enrollee who is billed by a hospital in violation of this subdivision may report receipt of the bill to the health care service plan and the department.

~~SEC. 3.~~

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or

infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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